North Carolina Department of Health and Human Services
Division of Mental Health, Developmental Disabilities and Substance Abuse Services
3001 Mail Service Center • Raleigh, North Carolina 27699-3001
Tel 919-733-7011 • Fax 919-508-0951

Michael F. Easley, Governor
Carmen Hooker Odom, Secretary

Michael Moseley, Director

March 7, 2005

MEMORANDUM

To:
Legislative Oversight Committee Members
Commission for MH/DD/SAS
Consumer/Family Advisory Committee Chairs
State Consumer Family Advisory Committee
Advocacy Organizations and Groups
North Carolina Association of County Commissioners
County Managers
County Board Chairs
North Carolina Council of Community Programs
State Facility Directors
Area Program Directors
Area Program Board Chairs
DHHS Division Directors
Provider Organizations
MH/DD/SAS Professional Organizations and Groups
MH/DD/SAS Stakeholder Organizations and Groups
Other MH/DD/SAS Stakeholders

From: Mike Moseley

Re: Communication Bulletin #033
CLINICAL SKILLS SERIES
Faculty Application

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services is seeking applicants interested in participating in "training of trainers" sessions on the new service definitions. Our goal is to identify a group of masters and doctoral level expert trainers who will be endorsed by the Division to offer training on the new and modified service definitions.

Candidates will receive specialized Division training and possible endorsement as an approved trainer in one or more of the service definitions. Endorsed faculty will be expected to make themselves available to teach Division-endorsed provider training sessions coordinated by public and private groups such as local management entities (LMEs), area health education centers (AHECs), community colleges, training consortiums, etc. in the current and upcoming fiscal year.

Please forward this application to anyone you know who may be interested in this opportunity. Applicants should submit the completed application, along with a current resume, by Monday, March 28, 2005.

Attachment

cc:
Secretary Carmen Hooker Odom
Lanier Cansler
DMH/DD/SAS Executive Leadership Team
Coalition 2001 Chair
Carol Duncan Clayton
Rob Lamme
Jim Klingler
Kaye Holder
Dick Oliver
Patrice Roesler

North Carolina Learning Community

Division of Mental Health, Developmental Disabilities and Substance Abuse Services

CLINICAL SKILLS SERIES
Faculty Application for Fiscal Years 2004-2005 and 2005-2006

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services is eager to identify and engage a select group of masters and doctoral level expert trainers to be endorsed by the Division to offer provider trainings in the proposed new and modified service definitions.

Candidates will receive specialized Division training and endorsement as an approved trainer in one or more of these proposed service definitions. Endorsed faculty will be expected to make themselves available to teach Division-endorsed provider training sessions coordinated by public and private groups such as local management entities, area health education centers (AHECs), community colleges, training consortiums, etc. in the current and upcoming fiscal year.

Please complete and return this faculty application, along with a current resume, by Monday, March 28, 2005. Please mail or fax the application and accompanying documentation to:

Lea Slaton, Planning Team, DMHDDSAS
3003 Mail Service Center
Raleigh, NC 27699-3003.
FAX (919) 733-1221

Please type or print

A. Please provide the following descriptive and demographic data.		
1. Your Name (First, Middle Initial, Last)		2. Date Application Completed
3. Your Current Job Title *(if applicable)*		4. Your Current Employer *(if applicable)*
5. Office Address *(if applicable)*		6. Office City, State, Zip Code *(if applicable)*
7. Home Address		8. Home City, State, Zip Code
9. Office Telephone		10. Home Telephone
Name & title of your immediate supervisor		Your Immediate supervisor's phone no. and e-mail address.
11. E-Mail	Fax	12.

B. Please provide the following descriptive and demographic data.	
1. Highest Professional Degree Attained (A minimum of a Masters Degree in a Human Services Field is required)	2. Field of Study of Highest Professional Degree
3. In what languages are you fluent?	
4. List all current relevant professional licenses and/or certifications, including expiration date and jurisdiction (state, federal, etc.)	

C. Please list your direct clinical practice and/or supervision experience with MH/DD/SAS populations.	
Area(s) of Direct Clinical or Supervision Experience By Primary Age/Disability of Population Served (Check *(✓)* all that apply)	No. of years of practice or supervision experience
1. ☐ Adult Mental Health	
2. ☐ Child Mental Health	
3. ☐ Adult Substance Abuse	
4. ☐ Child Substance Abuse	
5. ☐ Adult Developmental Disabilities	
6. ☐ Child Developmental Disabilities	
7. ☐ Other (Describe)	
8. Total Years of Clinical Experience	

D. Please briefly list your experience(s) in the past five years in providing professional training or education to adult learners in the health and human services field.

Organizational Sponsor of Training and Training Location	Training Topic(s)	Audience(s)	Dates(s) Delivered
1.		☐ Clinicians ☐ Program managers ☐ Paraprofessionals ☐ Consumers & families ☐ Advocacy groups ☐ Other (Specify)	
2.		☐ Clinicians ☐ Program managers ☐ Paraprofessionals ☐ Consumers & families ☐ Advocacy groups ☐ Other (Specify)	
3.		☐ Clinicians ☐ Program managers ☐ Paraprofessionals ☐ Consumers & families ☐ Advocacy groups ☐ Other (Specify)	
4.		☐ Clinicians ☐ Program managers ☐ Paraprofessionals ☐ Consumers & families ☐ Advocacy groups ☐ Other (Specify)	
5.		☐ Clinicians ☐ Program managers ☐ Paraprofessionals ☐ Consumers & families ☐ Advocacy groups ☐ Other (Specify)	

E. Please list at least two supervisory or management references who can attest to your training expertise and whom you grant permission to the Division to contact via your signature below.

Name of Reference Individual and Their Current Job Title	Reference's Current Place of Employment, City, State, Phone Number, E-mail.	How is Reference Aware of Your Training Expertise?
1.		
2.		
3.		
4.		

G. ☐ Yes ☐ No During the 18 months of your faculty appointment, will you be compensated by any entity receiving funding through the Division? If yes, describe.

H. Will you be teaching as an NC Learning Community faculty member during work time for another employer?

☐ Yes ☐ No If yes, please explain:

F. Please indicate your possible area(s) of interest in receiving specialized Division training and endorsement as a trainer in the following proposed new and modified service definitions. (Check *(✓)* all that apply)

- ☐ Community Support – Adults (MH/SA)
- ☐ Community Support – Children/Adolescents (MH/SA)
- ☐ Mobile Crisis Management (MH/SA)
- ☐ Diagnostic/Assessment (MH/SA)
- ☐ Intensive In-Home Services
- ☐ Multisystemic Therapy (MST)
- ☐ Community Support Team (MH/SA) (CST)
- ☐ Assertive Community Treatment Team (ACTT)
- ☐ Substance Abuse Intensive Outpatient Program (SAIOP)
- ☐ Substance Abuse Comprehensive Outpatient Treatment Program (SACOT)
- ☐ Ambulatory Detoxification
- ☐ Social Setting Detoxification
- ☐ Non-Hospital Medical Detoxification
- ☐ Medically Supervised or ADATC Detoxification/Crisis Stabilization
- ☐ Substance Abuse Non-Medical Community Residential Treatment
- ☐ Substance Abuse Medically Monitored Community Residential Treatment
- ☐ Substance Abuse Halfway House
- ☐ Psychiatric Residential Treatment Facility (PRTF)
- ☐ Developmental Disabilities Services
- ☐ Developmental Therapy Services
- ☐ Targeted Case Management for Individuals with Developmental Disabilities
- ☐ Psychosocial Rehabilitation
- ☐ Child and Adolescent Day Treatment (MH/SA)
- ☐ Substance Abuse Clinical Supervision

I. Please indicate below your availability to teach over the next 18 months.

☐ Days ☐ Weekends ☐ Nights

☐ 1-3 times every two months ☐ 1-3 times a month ☐ 4-6 times a month ☐ 1-3 times a quarter

☐ 4-6 times a quarter ☐ Other _____

I hereby attest that the information provided above is accurate and complete. I grant my permission to the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to contact my immediate supervisor and the references identified above to assist in evaluating this application.

Applicant Signature	Date Signed

Please complete and return this faculty application, along with a current resume, by Thursday, March 28, 2005. You may mail or fax the application and accompanying documentation to:

Lea Slaton, Planning Team, DMHDDSAS
3003 Mail Service Center
Raleigh, NC 27699-3003
FAX (919) 733-1221

Thank you for your interest in being considered as a candidate for faculty appointment to the Division's NC Learning Community.

Equal Opportunity Information

State Government policy prohibits discrimination based on race, sex, color, creed, national origin, age or disability. Sex or age is a bona fide occupational qualification in a small number of State jobs. The information requested below will in no way affect you as an applicant. Its sole use will be to see how well our recruitment efforts are reaching all segments of the population.

Date of Birth

_____
(mo.) (day) (year)

Check One

SEX ☐ M (male) ☐ F (female)

ETHNIC GROUP

1. ☐ White (non-Hispanic)
2. ☐ Black (non-Hispanic)
3. ☐ Hispanic (Mexican, Puerto Rican, Cuban, Central or South American, other Spanish origin regardless of race)
4. ☐ Asian (including Pacific Islander)
5. ☐ American Indian (including Alaskan native)

DISABILITY: "Disability means, with respect to an individual: (1) a physical or mental impairment that substantially limits one or more of the major life activities of such individual; (2) a record of such an impairment; or (3) being regarded as having such an impairment" (Americans with Disabilities Act of 1990). Persons without a disability should check item A.

The reporting of a **disability is strictly VOLUNTARY**. Persons with disabilities who **DO NOT WISH** to report their disabilities should check item A. Information reported on this form will be kept confidential as required by State law. Public disclosure of this information without your consent would be a violation of G.S.

- **A** ☐ None/Prefer not to report
- **B** ☐ Blind or severely visually impaired
- **C** ☐ Deaf or severely hearing impaired
- **D** ☐ Loss of limited use of arms and/or hands
- **E** ☐ Non-ambulatory (must use wheelchair)
- **F** ☐ Other orthopedic impairment (including amputation, arthritis, back injury, cerebral palsy, spina bifida, etc.)
- **G** ☐ Respiratory impairment
- **H** ☐ Nervous system/Neurological disorder
- **I** ☐ Mentally restored
- **J** ☐ Mental retardation
- **K** ☐ Learning disability
- **L** ☐ Others (heart disease, diabetes, speech impairment)
- **M** ☐ Other (please specify) _____